

# PROVIDER BULLETIN

## THE REIMBURSEMENT NEWS SOURCE

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MEDICAL SERVICES DIVISION

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MAGGIE D. ANDERSON,  
DIRECTOR

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Issue 63 • March 2008

## DURABLE MEDICAL EQUIPMENT

### AUDIOLOGISTS:

- It has come to the attention of the Department that some providers are not following their Medicaid contractual agreement. It is the provider's responsibility to inform a client, or client's parents, that if Medicaid is the secondary payer, providers are required by their agreement to prior authorize and bill the Department as usual for hearing aids.

Furthermore, payment received from the Department is considered payment in full.

The information that we have received involved recipients who had other primary insurance that did not completely cover the usual and customary price of a hearing aid. In these instances, the providers attempted to bill the recipient rather than prior authorizing and billing the hearing aid through Medicaid.

- For claims or prior authorization approval status, call 701-328-4030 or 701-328-4043. If Provider Relations is unable to answer your questions, they will forward the call to the appropriate individual.

### ALL PROVIDERS:

- When submitting prior authorization (PA) for durable medical equipment, it is imperative that the recipient information, i.e., place of residence, is current. Incorrect recipient information may cause the PA/claim to be adjudicated/paid incorrectly.
- If a provider has received a PA back with a denial reason of "41" (i.e., invoice or CMN not attached) resubmit the PA as soon as possible along with the requested information. When the information is sent back to Medicaid, indicate on the cover letter that the request is for reconsideration due to denial reason "41".
- To ensure that prior authorizations are adjudicated in a timely manner, be sure the PA is completed in full before submitting to Medicaid. Refer to the DME Provider Manual, or the Prior Authorization Form Completion Guide on the back of the form for instructions on how to complete a PA.

## CSP RECIPIENTS WITH DUAL ELIGIBILITY

All Coordinated Services Program (CSP) recipients with dual eligibility (recipients who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid Benefit) that receive medical services must follow the CSP requirement guidelines. Effective November 22, 2007, all claims where the recipient is dually eligible will be denied for patient responsibility if CSP program requirements are not followed.

The CSP Program is a managed care program that follows the primary physician concept where

one physician manages all of the patient's medical needs. The CSP physician will make referrals to specialists and other services outside the CSP specialty as needed.

Medicaid recipients who receive services not authorized by their CSP physician before services are received, will be responsible for all services.

Recipients who seek emergent/urgent care will be responsible for payment if services are determined to be non-emergent/urgent.

## CIRCUMCISIONS

Routine circumcision, regardless of age, is not a service covered by ND Medicaid. Non-routine circumcisions must be prior authorized. The history of complications (i.e. Balanitis, recurrent urinary tract infections) substantiating the medical necessity must be submitted with the prior authorization request.

## COBA CLAIMS

ND Medicaid has finished inputting the backlog of COBA claims into MMIS. Claims that have not appeared on a provider's remittance advice or are not in ND Medicaid's suspense files must be submitted for adjudication. Providers may request a suspense listing by calling 1-701-328-4030.

## FLUORIDE VARNISH CODING GUIDELINES

The updated coding guideline for fluoride varnish is effective for dates of service beginning July 1, 2007. Please note the new HCPC code required to bill ND Medicaid for topical fluoride varnish application.

### **HCPC CODE: D1206 –**

Topical fluoride varnish; therapeutic application for moderate to high caries risk patients

### **CRITERIA:**

- Patient must be age 6 months to 21 years
- Recommend the fluoride varnish be applied at the time of a well child visit / Health Tracks screening
- Allow a maximum of two (2) applications per year, per patient
- The following professionals may perform the procedure **after receiving**

### **board approved training:**

- a. Nurse Practitioners
- b. Registered and Licensed Practical Nurses under the direct supervision of a physician (claim must be submitted under the physician's NPI)
- c. Registered Dental Hygienist or Registered Dental Assistant under the direct, or general, supervision of a licensed dentist. (Claim must be submitted under the dentist's NPI)

NOTE: This service is currently covered when rendered by a dentist.

### **COVERED DIAGNOSIS:**

V07.31 - Prophylactic fluoride

This guideline supersedes previous Fluoride Varnish coding guideline.

# CLAIMS

## ELECTRONIC CLAIMS

All electronic claims are required to have the NPI (National Provider Identifier) in the primary position when a provider identifier is entered, whether it is for the billing, referring, attending, rendering, and/or operating provider. Failure to comply with this requirement will result in claims denying for the following **NPI denials** reasons:

- N253–Missing/incomplete/invalid attending provider primary identifier
- N257–Missing/incomplete/invalid billing provider primary identifier
- N270–Missing/incomplete/invalid other provider primary identifier
- N286–Missing/incomplete/invalid referring provider primary identifier
- N290–Missing/incomplete/invalid rendering provider primary identifier

Reminder - All NPI numbers must be registered on the DHS/Medicaid website, PRIOR to billing, using the NPI. Go to [www.nd.gov/dhs/providers/](http://www.nd.gov/dhs/providers/), and then click on the link “Register your NPI with ND Medicaid”. Only ND Medicaid enrolled providers may register an NPI with ND Medicaid.

## SUBMITTING PAPER CLAIMS

The North Dakota Medicaid Provider number is required on all paper CMS 1500 or UB04 claim forms. The NPI number is optional on paper claims and is to be entered as a secondary number.

- The billing Provider Number is located in box 33 on the CMS 1500 and box 57 on the UB04.
- The rendering Provider Number is located in box 24j on the CMS 1500 and box 76 on the UB04.
- The referring Provider Number is located in box 17 and 17a on the CMS 1500. We currently accept the UPIN or ND Medicaid provider number for the Referring Provider.

## RESUBMITTING PROCESSED CLAIMS:

- CMS-1500 claim form – The ICN (Internal Control Number) and Remittance Advice date is required in box 22 to indicate when the claim processed last.
- UB04 claim form - The ICN (Internal Control Number) and Remittance Advice date is required in box 80 to indicate when the claim processed last.

## HOSPITALS BILLING INPATIENT SERVICES – FOR FACILITIES NOT PAID BY DRG:

Critical Access, Long Term Care, Psychiatric, Rehabilitation, and Out-of-State Hospitals billing for Inpatient Services where a Medicaid recipient is discharged in a month subsequent to the month of admission are required to bill each month of the inpatient stay on a separate claim form. Claims that cover more than 1 month will not be processed and will be returned to the provider.

If a recipient has Medicaid, and does not have primary insurance, and the patient status is ‘still a patient’, you may submit a claim at the end of each month.

If a recipient has primary insurance (Medicaid is secondary), please hold all claims (months) until the recipient is discharged. Submit all months related to the inpatient stay on separate claims along with a copy of the EOB from the primary insurer. Do not submit claims for months in which the recipient is ‘still a patient’ until the recipient is discharged and an EOB from the primary insurer is available for submission with the claims. Claims received with a status code of ‘still a patient’ where primary insurance is indicated, and there is no claim for the discharge month, will be returned to the provider.

Continued on Page 4

# CLAIMS - CONTINUED

## CRITERIA FOR SUBMISSION OF PAPER CLAIMS, ADJUSTMENT AND ATTACHMENTS:

Hard copy claims, adjustments and attachments must meet the following criteria to ensure that all documents can be scanned and processed in a timely manner. Documents not meeting the following criteria will be returned to the provider.

- Use only black (preferable) or blue ink. Do not use red ink.
- Do not staple documents together.
- We receive many overstuffed envelopes. This can cause the material to become damaged, partially received, or lost altogether before it arrives in our office.
  - We recommend including no more than four sheets of paper per regular #10 envelope. When submitting more than four pages, a larger “flat” envelope that measures roughly 9”x12” should be used. This will reduce the amount of claims damaged during the opening process, as well as lessen problems experience with running folded claims through the scanner.
  - If you are submitting folded claims, one of the “thirds” should be larger than the other two. This will leave a small amount of space in the envelope that will allow our envelope opening equipment to cut open the envelope without damaging the claims. Please do not fold claims into equal sections.
- Do not use highlighter or liquid white out.
- All information must be legible, typed (preferably Arial or Helvetica font) or printed, and within the boxes. Information must not touch or cover the lines of the claim form.
- Submit documents on 8½ X 11 white paper. If document is smaller or larger than this size, copy it to 8½ X 11 white paper.
- Do not submit carbon or NCR copies.
- Documents cannot have any dark smudges, blackouts, or dark print that runs together.
- Do not place any labels, stickers, or tape on documents.
- Do not submit two-sided documents.
- Do not use dashes or slashes in the Recipient ID, Patient Account Number or other fields.
- Only one line of service is allowed per detail line on the claim or adjustment form. Do not bill with two service lines compressed into one detail line.

## WHEN TO FILE AN ADJUSTMENT:

- If claims deny for PCP (Reason “38” on your Remittance advice), you will need to submit an adjustment with the referral attached from the PCP. In block 17 (a) on the adjustment form (SFN 639) you will need to identify the PCP; name and UPIN and/or Medicaid Provider number.
- If claims are denied for any other reason, you will need to submit a new corrected claim with all attachments.
- If the claim was originally billed electronically and paid incorrectly, and Medicaid is secondary, you will need to send in an adjustment and attach a corrected claim to the adjustment form with the correct EOB from the recipient’s primary insurance.
- For your reference, a sample “Provider Request for An Adjustment” form is on the following page. A fillable copy of the form is available at: <http://www.nd.gov/eforms/Doc/sfn00639.pdf>

**PROVIDER REQUEST FOR AN ADJUSTMENT**

ND DEPARTMENT OF HUMAN SERVICES

SFN 639 (Rev. 08-2002)

STATE USE ONLY

**(1) Reason for Request:**

- ☐ A. No Payment Received    ☐ B. Overpayment    ☐ C. Underpayment    ☐ D. Corrected Billing Attached  
☐ E. Paid to Wrong Provider    ☐ F. Cannot Identify Beneficiary on Explanation of Benefits    ☐ G. Lost Check  
☐ H. Other (Please Clarify Under Remarks)

**(2) Recipient Block:**

a. I.D. Number (9 digits)

999-999-999

b. State Use Only  
Base ID

c. Patient's Name

Doe, John

d. Case Number (10 digits)

**(4) Claim's Internal Control Number: (13 digits)**

1007999999999

**(3) Provider's Name:**

Medicaid Provider's Name

**(5)**

Address

Medicaid Provider's Address

**(6) Provider Number:**

19999

City

State

Zip Code

**(7) Remittance Advice Date: (MM/DD/YY)**

01/01/07

**(8) Date of Service:**From Thru  
Mo Day Yr Mo Day Yr(9)  
Units(10)  
Place of  
Service(11)  
Procedure/Ancillary/  
Accommodation(12)  
Mod(13)Tooth No./  
Tooth Sur.(14)  
Amount Billed(15)  
Amount Paid

01	01	01	01	01	01							96	00	46	00

**(17) Explanation/Remarks:****(16) Total**

\$ 96 00 \$ 46 00

This area needs to be completed.

**Medical Services**

**N.D. Department of Human Services**  
**600 E. Boulevard Ave Dept 325**  
**Bismarck, ND 58505-0250**

**(19) Provider's Signature:**

Date (MM/DD/YY)

12/07/07

Provider

Telephone Number

By

ND DEPT OF HUMAN SERVICES  
DIVISION OF MEDICAL SERVICES  
600 E BOULEVARD AVE DEPT 325  
BISMARCK ND 58505-0250

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- ☐ Billing clerks
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- ☐ Other Appropriate  
Medical Personnel

Please make copies as  
needed.

## CHECK-WRITE EXCEPTION DATES

Typically, check-write occurs every Monday evening; however, there will be the following exceptions for 2008:

No Check-Write	Rescheduled Date
March 31, 2008	April 1, 2008
May 26, 2008	May 27, 2008
June 30, 2008	July 1, 2008
September 1, 2008	September 2, 2008
December 1, 2008	December 2, 2008

## NEW FACES IN MEDICAL SERVICES

- ☺ Tammy Renner – Admin., Utilization Review
- ☺ Pam Nemeth – Admin., Medicaid Eligibility
- ☺ Amanda M. – Claims Auditor
- ☺ Barb Masset - Admin., Medicaid Eligibility
- ☺ Jake Reuter – Program Manager, Money  
Follow the Person Grant
- ☺ Sandy Kuntz – Admin., Medicaid Eligibility
- ☺ Michelle A– Claims Auditor, Dental & Vision
- ☺ Kathy Barchenger – Program Manager,  
Children’s Medicaid Waiver
- ☺ Sara Regner – New Position – Medical  
Coding Specialist
- ☺ Karen Larson – Administrator,  
DD Grants & Rate Setting